CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

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GENERAL INFORMATION

The Virginia Medical Assistance Program covers the following vision care services for Medicaid recipients:

Services	Recipient Age Limit
Diagnostic examinations and optometric treatment procedures and services	All Ages
Eye exercises (Orthoptics)	Only under 21
Lenses	Only under 21
Frames	Only under 21
Repair of lenses or frames	Only under 21
Professional ophthalmic dispensing fees	Only under 21
Medically necessary contact lenses (must be preauthorized)	Only under 21
Eye Prostheses	All Ages

RECIPIENT COPAY POLICY

All recipients are liable for copayments for vision services except for those under age 21 and individuals receiving long-term care services or hospice care. A $1.00 copayment should be collected for eye examinations and for non-emergency vision analysis (refractions) given to all recipients identified by Special Indicator (SI) Code C (through verification). Medicaid payment to vision care providers will be reduced by the recipient copayment amount.

FREEDOM OF CHOICE OF PROVIDER

Virginia Medicaid recipients are free to choose any participating vision provider licensed by the State Regulatory Agency to provide a particular vision service. Recipients may choose either the same provider for purchasing glasses or a different provider from the one who performed the vision analysis.

COVERED SERVICES AND LIMITATIONS

The following reflects Virginia Medicaid covered services and coverage limitations related to vision service.

Diagnostic Examinations and Other Optometric Treatment Procedures

- A **routine** comprehensive eye examination as defined under Comprehensive Ophthalmological services in the American Medical Association CPT Code Book, is allowed only once every 24 months. The National Standard Code for this service is found in Appendix B. For extenuating medically indicated circumstances where less than 24 months have elapsed since the last examination, explain the situation on an attachment to the CMS-1500 (12-90).

  For **non-routine** eye examinations and other optometric treatment procedures, which the provider is qualified by his or her license to perform, use CPT five-digit codes found in the AMA CPT code book. These books may be purchased from:

  Order Department: OP 054192
  American Medical Association
  Post Office Box 10950
  Chicago, IL 60610-0946

- **Eye Exercises** (orthoptics) are covered **only** for persons under 21 years of age under Virginia Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Reimbursement will be provided for medically indicated orthoptics based on an EPSDT referral to a Medicaid participating EPSDT provider: an ophthalmologist or an optometrist.

  All orthoptic sessions must be medically necessary. If more than six sessions are required, the seventh and subsequent sessions billed to Medicaid requires written documentation supporting the continuing need. This documentation must be attached to the CMS-1500 (12-90). The CMS-1500 (12-90) will be reviewed by DMAS medical consultants and be approved for payment as appropriate. The appropriate CPT/HCPCS code for orthoptics is 92065-orthoptic and/or pleoptics training, with continuing medical direction and evaluation.

Lenses (Under 21 Years of Age)

- Lens charges must reflect only the provider's laboratory costs; they may not exceed the average and reasonable wholesale costs.
- HCPCS procedure codes for lenses are found in Appendix B.

- Attach the supplier's invoice where possible.
    - For more expensive lenses, place a "22" modifier in Locator 24D of the CMS-1500 (12-90) and explain the medical justification on an attachment.
    - Each lens is considered a separate procedure and should be billed as "1" or "2" in Locator 24G of CMS-1500 (12-90).
- Ophthalmic lenses may be made of either: (1) plastic with scratch-resistant coating or (2) glass.
- Tinted lenses are covered only when they can be medically justified (e.g., photophobia, albinism).
- Photogray lenses and lenses for cosmetic purposes are not covered by the Program.
- Contact lenses are not covered under the Program unless medically necessary. Medical justification for preauthorization must be sent to:

    Department of Medical Assistance Services
    Director of Medical Support
    600 E. Broad Street, Suite 1300
    Richmond, VA 23219

Eyeglass Frames

- Frame charges must reflect only the provider's actual laboratory cost; they may not exceed the average and reasonable wholesale cost.
    - The appropriate HCPCS procedure code for frames is found in Appendix B.
    - For special medically justified frames, place a "22" modifier in Locator 24D of the CMS-1500 (12-90) and explain the medical justification on attachment.
    - The entire eyeglass frame is billed as one procedure.
- Eyeglass frames should be durable ZYL frames (plastic), such as Opti-Colors. Wire frames are covered, however, Medicaid will not reimburse the provider any more for wire frames than the provider would receive for plastic frames. The provider cannot balance bill the recipient for any difference in cost.

Repair of Eyeglass Frames And/Or Replacement Of Broken Lenses

- The appropriate HCPCS procedure codes are are found in Appendix B.

- The repair of frames and lenses is normally limited to once every 12 months. If a repair is made in less than 12 months, place "22" modifier in Locator 24D of CMS-1500 (12-90) and explain the medical justification on an attachment. Attach a medical justification statement and a detailed repair statement including the costs.

- The repair or replacement of non-covered services is not covered by the Program.

Professional Ophthalmic Dispensing Service

- Professional services, such as measuring, fitting, verifying, and adjusting the eyeglasses and providing an eyeglass case, are covered services. There are no corresponding national codes to bill for the lens or frames dispensing fees. The frames dispensing fee will be included in the frames purchasing fee. The lens dispensing fee will be added to the HCPCs code billed for the lens.

Note: Provider charges should include the lens dispensing fee. If a lens HCPCs code is priced for individual consideration (HCPCs codes V2100 to V2118, V2200 to V2220, V2300 to V2309 and V231), the provider should submit their actual invoice cost.

Ocular Prostheses

Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Preauthorization is not required, but post-payment review is conducted.

VISION CARE PROVIDER'S ROLE IN THE PRESCRIPTION DRUG PROGRAM

Ophthalmologists and optometrists licensed by a state regulatory agency to prescribe drugs may prescribe legend drugs for Medicaid recipients.

The provider's normal procedure for prescribing drugs should be followed. However, the prescriber's Medicaid provider number must be included on all prescriptions for Medicaid recipients.

The prescribing of drugs should be in accordance with community standards of medical and pharmacological practices and consistent with economy. Physicians are expected to write generic prescriptions, specifying a brand name only when it is medically necessary. In acute illnesses, prescribed drugs should be limited to the quantity needed for the course of treatment for the illness. Maintenance drugs for chronic illnesses should be prescribed in quantities reflecting at least a 30-day supply or 100 units/doses, except when contraindicated by the patient's physical or psychological condition.

Coverage and Limitations

Prescription services are provided to Medicaid recipients as described below.

Legend drugs are covered except for the following:

- Anorexiant drugs prescribed to suppress appetite; however, prior authorization may be requested if the medical indication is to treat attention deficit disorders or narcolepsy. If approved, reimbursement is allowed for the prescription only from one pharmacy selected by the patient and when prescribed by one designated provider. Utilization is monitored.

- DESI (Drug Efficacy Study Implementation) drugs considered by the Food and Drug Administration (FDA) to be less than effective. Compound prescriptions, which include a DESI drug are not covered. A current list of the DESI drugs is provided in Appendix C of this manual and will be updated by periodic replacement pages to this manual.

  EXCEPTION: Dipyridamole, under the brand name Persantine only, is covered when prescribed for the FDA-approved indication: as an adjunct to Coumarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacements. Physicians must indicate the diagnosis on the prescription. The pharmacist may submit a claim for reimbursement only when the approved diagnosis is documented, and the documentation must remain on file in the pharmacy.

  Dipyridamole products other than the brand name Persantine are classified as DESI drugs and are not covered by Medicaid.

- Investigational/experimental drugs and drugs which have been recalled.

- Food services and dietary or nutritional supplements that do not constitute a legend/schedule drug under Virginia law EXCEPT when preauthorized and EXCEPT as provided for in a hospital or nursing facility and included in the overall cost of inpatient care. Supplements will be preauthorized through home health only when the supplements are required as the sole source and are administered via mechanical device. Supplements may be authorized through EPSDT or the technology-assisted or AIDS waiver when the supplements are required as the primary nutritional source.

  NOTE: Retrovir is covered to treat patients with symptomatic HIV (Human Immunodeficiency Virus) infections (AIDS and advanced ARC, Aids-Related Complex). No special procedures are required for prescribing

this drug.

Non-legend drugs (over-the-counter) are only covered as described below:

- Coverage is allowed for the following:
  - Family planning drugs and supplies
  - Insulin
  - Syringes and needles, **except** for recipients residing in nursing facilities
  - Diabetic test strips for recipients under 21 years of age
- Specific therapeutic categories, which are covered for nursing facility recipients are:
  - Analgesics
  - Antacids
  - Antidiarrheal
  - Antivertigo preparations
  - Cough and cold preparations
  - Dermatologicals
  - Hemorrhoid preparations
  - Laxatives
  - Ophthalmic preparations
  - Vitamins, minerals, and hematinics

Copayment on Drugs

Recipients are required to pay the dispensing pharmacy $1.00 for generic drugs and $3.00 for brand name drugs for each original and refill legend drug prescription, insulin, syringes, and needles. This copayment does not apply to recipients under age 21, institutionalized patients, hospice patients, and pregnancy-related or family planning drugs and supplies.

Multiple Source Drugs - Payment Basis

Under the authority of 1902 (a) (30) (A) and the regulations in 42 CFR 447.332, the Centers for Medicare and Medicaid Services (CMS) establishes a specific upper limit for certain multiple source drugs if the following requirements are met:

- All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications).
- At least three suppliers list the drug, which has been classified by the FDA as category "A" in its publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications) and in the current editions (or updates) of published compendia of cost information for drugs available for sale nationally (e.g., Red Book, Blue Book,

Medi-Span).

The upper limit for multiple source drugs for which a specific limit has been established does not apply if a physician **certifies in his or her handwriting that a specific brand is "medically necessary"** for a particular recipient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A checkoff box on a form is not acceptable. The "brand necessary" documentation requirement applies to telephoned prescriptions. **This certification authorizes the pharmacist to fill the prescription with the requested brand name product and not to dispense the generic product listed in the Virginia Voluntary Formulary.**

In addition, the Department of Medical Assistance Services has established a Virginia Maximum Allowable Cost for some multiple source drugs listed in the Virginia Voluntary Formulary, which are not designated as federal maximum allowable drugs. Again, unless the physician follows the procedures outlined above for specifying a brand necessary drug, the Virginia Maximum Allowable Cost per unit will be used to determine the allowable payment.

CLIENT MEDICAL MANAGEMENT

As described in Chapters III and VI of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for services to these recipients only:

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient.
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from Client Medical Management Program requirements.

Routine vision care services (routine diagnostic exams for recipients of all ages and eyeglasses for recipients under age 21) provided to restricted recipients are excluded from the requirement for a written referral. These are services billed using codes listed in Appendix B of the *Vision Care Manual*.

Medical treatment for diseases of the eye and its appendages requires a written referral or may be provided in a medical emergency. Ophthalmologists and other physicians skilled in the treatment of diseases of the eye and its appendages must coordinate medical treatment with the primary care physician. The primary care physician must complete a Practitioner Referral Form (DMAS-70) when making a referral to another physician or clinic. The referral physician must follow special billing instructions found in this manual

to receive reimbursement for restricted recipients.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The Medicare Catastrophic Coverage Act of 1988 and other legislation require state Medicaid programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit less the recipient's copayment on allowed charges for all Medicare-covered services. The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY—QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

EXHIBITS

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

EMERGENCY MEDICAL CERTIFICATION

FROM:

I. REFERRAL SECTION

TO: SUPERVISOR, DIVISION OF HEALTH SERVICES REVIEW
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

APPLICANT NAME: _____

CASE NUMBER: _____

THE ABOVE-NAMED INDIVIDUAL IS A NON-RESIDENT ALIEN WHO HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____ (DATE). ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____ WORKER # _____ DATE: _____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINE THAT THE MEDICAL CONDITION

☐ IS AN EMERGENCY. ☐ IS NOT AN EMERGENCY.

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED: _____ TITLE: _____ DATE: _____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS. REASON FOR DENIAL: _____

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____ TITLE: _____ DATE: _____

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LOCAL AGENCY